

# Missouri 2006 Benefit Addendum

to the Individual Health Insurance Application

## Product Selection

Please mark appropriate deductible, coinsurance and optional benefit(s) for product selected.

**Key Applicant** \_\_\_\_\_

**PPO Network**     HealthLink     Open Access II     PHCS

**Community Med HSA**

<b>Coinsurance</b> (Network/Non-Network)	<input type="checkbox"/> 100%/75% <input type="checkbox"/> 80%/50%	
<b>Deductible</b> (Network/Non-Network) <small>The network and non-network deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.</small>	<input type="checkbox"/> Individual (Calendar Year)	<input type="checkbox"/> Family (Calendar Year)
	<input type="checkbox"/> \$1,050*/\$2,100* <input type="checkbox"/> \$1,500/\$3,000	<input type="checkbox"/> \$2,100*/\$4,200* <input type="checkbox"/> \$3,000/\$6,000
	<input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$2,600/\$5,200	<input type="checkbox"/> \$4,000/\$8,000 <input type="checkbox"/> \$5,200/\$10,400
	<input type="checkbox"/> \$3,500/\$7,000	<input type="checkbox"/> \$7,000/\$14,000
	<input type="checkbox"/> \$5,000**/\$10,000**	<input type="checkbox"/> \$10,000**/\$20,000**
<small>* Not available on the 100%/75% Coinsurance    ** Not available on 80%/50% Coinsurance</small>		
<b>Optional Benefits</b>	<input type="checkbox"/> Dental <input type="checkbox"/> Maternity	
<b>HealthEquity</b>	By selecting the Community Med HSA plan you authorize HealthEquity to open a Health Savings Account (HSA) according to the HealthEquity Service Agreement you will receive in the mail. <input type="checkbox"/> Check here if you do not wish to open an HSA fund.	

**Medalist**

<b>Coinsurance</b> (Network/Non-Network)	<input type="checkbox"/> 80% of \$5,000/50% of \$10,000 <input type="checkbox"/> 80% of \$10,000/50% of \$20,000
	<input type="checkbox"/> 70% of \$5,000/50% of \$10,000 <input type="checkbox"/> 70% of \$10,000/50% of \$20,000
<b>Copay with Deductible</b> <b>OR</b>	<input type="checkbox"/> \$25, \$500/\$1,000 <input type="checkbox"/> \$30, \$1,000/\$2,000 <input type="checkbox"/> \$35, \$1,500/\$3,000
	<input type="checkbox"/> \$40, \$2,500/\$5,000 <input type="checkbox"/> \$40, \$5,000/\$10,000
<b>Deductible Only</b>	<input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$1,000/\$2,000 <input type="checkbox"/> \$1,500/\$3,000
	<input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$5,000/\$10,000
<b>Prescription Drugs</b>	<input type="checkbox"/> Scheduled Copay <input type="checkbox"/> \$1,000 Deductible, then Scheduled Copay
<b>Optional Benefits</b>	<input type="checkbox"/> Dental <input type="checkbox"/> Maternity

**Accidental Death & Dismemberment Beneficiary - For Community Med HSA only**

*(If no beneficiary is listed, the benefit will default to your estate)*

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

**Contraceptive Coverage Opt-Out:** If the use of contraceptives, contraceptive methods or aids conflicts with the moral, ethical, or religious beliefs of the key applicant, the key applicant may elect to waive coverage of these items. If you would like to waive coverage, please initial here \_\_\_\_\_ .

# Missouri

## Application for Health Insurance

### through American's Individual Trust

Please complete application in blue or black ink.

Thank you for applying to American Community Mutual Insurance Company (*herein referred to as American Community or AC*). Please take the time to carefully complete this application. Your answers will become part of the underwriting process and the insurance contract.

#### A. TYPE OF APPLICATION

- New Application       Change to a new policy with AC. Current Policy # \_\_\_\_\_
- Add Dependents to Policy # \_\_\_\_\_ Key Insured \_\_\_\_\_  
(Please indicate information only on the dependents to be added to the policy.)
- Was an American Community Short Term application submitted with this application?     Yes     No

#### B. PERSONS APPLYING FOR INSURANCE

1. **List all Family Members applying for insurance.** Children must be at least 15 days old and under 22 years old. Include maiden names of females in parentheses. To qualify as a full time (FT) student (for children between the ages of 18 and 22), a child must be enrolled in a minimum of 12 credit hours at a college, university, or trade school.

Full Name First-Middle-Last (Include Maiden Name if used within past 5 yrs.)	Relationship to Applicant	Sex M/F	Date of Birth	Height FT. IN.	Weight LBS.	Social Security Number	✓ if FT Student
	Key Applicant						
	Spouse						
	Child						
	Child						

#### 2. Home Address

Street		
City	State	Zip
County		

#### 3. Billing Address if other than Home Address

Name		
Street		
City	State	Zip

4. If any proposed applicant does not live at the above address, please explain: \_\_\_\_\_

#### 5. Contact Numbers

Daytime Ph. #
Evening Ph. #
Spouse's Ph. #
Email Address

#### 6. Occupation(s)

Key Applicant Occupation:
Spouse Occupation:

#### You may be contacted for a telephone interview.

Please indicate the best time (between 8:00 am and 5:00 pm Eastern Standard Time) for an interview: \_\_\_\_\_

#### C. EXISTING COVERAGE AND REPLACEMENT

Does any applicant meet the definition of a Federally Eligible Individual as defined by HIPAA?     Yes     No

If yes, please attach the applicable Certificates of Creditable Coverage.

Are any Applicants covered by other health insurance now?     Yes - Complete section below     No

Will this coverage be replaced by this policy if issued?     Yes     No - **Desired effective date:** \_\_\_\_\_

Applicant(s) Name(s)	Insurance Company Name	Group or Individual	Certificate or Policy Number	Effective Date	Termination Date

#### D. BENEFITS REQUESTED

Please complete and attach either the American Community or Precedent Benefit Addendum identifying the Health Plan selected.

**E. PREMIUM PAYMENT INFORMATION**

Estimated monthly premium quoted by agent \$ \_\_\_\_\_

**INITIAL PREMIUM PAYMENT OPTIONS:** (make checks payable to American Community Mutual Insurance Company)

- Credit Card
- Check \$ \_\_\_\_\_
- EFT (Only if EFT is chosen as the billing option)

**INITIAL PREMIUM SHORTAGE OPTIONS:**

- Credit Card
- Bill Me
- EFT (Only if EFT is chosen as the billing option)

Please complete Credit Card and/or EFT information if you have selected them as a Premium Payment Option.

**CREDIT CARD** (for initial payment only)

- MasterCard** Card Holder Name: \_\_\_\_\_
- Visa** Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
- Signature: X** \_\_\_\_\_ Date signed: \_\_\_\_\_

**BILLING FREQUENCY:**

- Monthly\*
- Quarterly
- Semi-Annually
- Annually

**BILLING OPTIONS:**

- Bill Me
- EFT (Electronic Fund Transfer)
- New List Bill\* (List Bill Agreement Required)
- List Bill # \_\_\_\_\_

Employer name for List Bill \_\_\_\_\_

\*Administrative Charge: Once approved, an additional Monthly Billing Fee of \$4.75 will be applied (fee is waived for EFT, Quarterly, Semi-Annually, or Annually). List Bills include a \$10 monthly Billing Fee.

**ELECTRONIC FUNDS**

**TRANSFER (EFT)**

- Checking
  - Savings
- (If allowed by bank)

Name of Financial Institution: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Account Holder's Name: \_\_\_\_\_

Transit Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

**Authorization Agreement For Electronic Funds Transfer for Premium Payment**

I authorize American Community Mutual Insurance Company (Company) to initiate monthly electronic withdrawals, in the amount of the then-current monthly premium rate, from the account and financial institution (Bank) named above. This authority remains in effect until Company and Bank receives written notification from me of its termination in such time and manner as to give Company and Bank a reasonable opportunity to act on it. Company reserves the right to void this agreement at any time without prior notice.

**Signature: X** \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Returned Check Fee:** If any premium payment made directly by check or by Electronic Funds Transfer (EFT) is returned for non-sufficient funds, a nonrefundable service fee will be charged.

**F. QUESTIONS APPLY TO EACH PERSON APPLYING FOR COVERAGE (APPLICANTS)**

Please answer all questions.

- |  | Yes                      | No                       |  | Yes                      | No                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you, your spouse, significant other, or any dependent or adopted child now pregnant or have an adoption pending? <b>If yes, Do Not Submit Application.</b>  | <input type="checkbox"/> | <input type="checkbox"/> | 4. Does any applicant engage in scuba or sky diving, organized racing, flying or other hazardous activities? If yes, who? _____<br>What activity? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has any applicant lived outside the United States within the past 12 months or does any applicant plan to travel outside the United States in the next 12 months? If yes, who? _____<br>Where? _____ When? _____  | <input type="checkbox"/> | <input type="checkbox"/> | 5. Did or does any applicant consume, on average, more than 2 alcoholic beverages ( <i>one beverage equals one 12 oz. beer or one 4 oz. wine or 1 oz. of liquor</i> ) per day in the past year? If yes, please complete the Alcohol/Drug Questionnaire.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any applicant in the last 12 months smoked cigarettes, cigars, pipes or used any form of tobacco, including chewing tobacco or nicotine products? If yes, who? _____<br>Form of tobacco used: _____<br>Number of years used: _____<br>If quit, please provide date of last use: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 6. Has any applicant's driver's license been suspended or revoked in the last 10 years? If yes, please provide their name and driver's license number.<br>Name: _____<br>Driver's license number: _____<br>If yes, and alcohol or drugs were related to suspension/revocation, please complete Alcohol/Drug Questionnaire. | <input type="checkbox"/> | <input type="checkbox"/> |

(continued on next page)

Within the last 10 years, has any applicant had symptoms of; or a diagnosis of; or received treatment, including but not limited to medications for; or had testing for; or consulted with a physician or medical professional concerning:

Answer each question and document details of any "Yes" answers on page 4.

	Yes	No		Yes	No		Yes	No
7. Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	46. Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	84. Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>
8. Abnormal test results	<input type="checkbox"/>	<input type="checkbox"/>	47. Elevated Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	85. Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
9. Adrenal Gland Disorders	<input type="checkbox"/>	<input type="checkbox"/>	48. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	86. Muscular Disorders	<input type="checkbox"/>	<input type="checkbox"/>
10. Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	49. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	87. Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
11. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	50. Eye Disorders	<input type="checkbox"/>	<input type="checkbox"/>	88. Nervous System Disorders	<input type="checkbox"/>	<input type="checkbox"/>
12. Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	51. Female Disorders	<input type="checkbox"/>	<input type="checkbox"/>	89. Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
13. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	52. Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	90. Osteoporosis or		
14. Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	53. Foot Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
15. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	54. Gallbladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	91. Pancreas Disorders	<input type="checkbox"/>	<input type="checkbox"/>
16. Arthritis/gout	<input type="checkbox"/>	<input type="checkbox"/>	55. Gastric bypass	<input type="checkbox"/>	<input type="checkbox"/>	92. Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
17. Artificial limb or prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	56. Gastric reflux	<input type="checkbox"/>	<input type="checkbox"/>	93. Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
18. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	57. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	94. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
19. Autism	<input type="checkbox"/>	<input type="checkbox"/>	58. Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	95. Polyp	<input type="checkbox"/>	<input type="checkbox"/>
20. Autoimmune Disorders	<input type="checkbox"/>	<input type="checkbox"/>	59. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	96. Pregnancy Complications	<input type="checkbox"/>	<input type="checkbox"/>
21. Back or spine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	60. Heart Disorders	<input type="checkbox"/>	<input type="checkbox"/>	97. Prostate Disorders	<input type="checkbox"/>	<input type="checkbox"/>
22. Bladder Disorders	<input type="checkbox"/>	<input type="checkbox"/>	61. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	98. Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
23. Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	62. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	99. Reproductive System		
24. Breast Disorder	<input type="checkbox"/>	<input type="checkbox"/>	63. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Disorders	<input type="checkbox"/>	<input type="checkbox"/>
25. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	64. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	100. Respiratory Disorders	<input type="checkbox"/>	<input type="checkbox"/>
26. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	65. High Blood Pressure			101. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
27. Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	(provide last 3 pressures			102. Shoulder Disorder/Injury	<input type="checkbox"/>	<input type="checkbox"/>
28. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	and dates)	<input type="checkbox"/>	<input type="checkbox"/>	103. Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>
29. Cesarean Section	<input type="checkbox"/>	<input type="checkbox"/>	66. Hodgkin's Disease	<input type="checkbox"/>	<input type="checkbox"/>	104. Skin condition	<input type="checkbox"/>	<input type="checkbox"/>
30. Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	67. Infertility	<input type="checkbox"/>	<input type="checkbox"/>	105. Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>
31. Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>	68. Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	106. Speech Impairment	<input type="checkbox"/>	<input type="checkbox"/>
32. Chronic infections	<input type="checkbox"/>	<input type="checkbox"/>	69. Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	107. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
33. Chronic Obstructive			70. Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	108. Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Disease			71. Joint Disorders/	<input type="checkbox"/>	<input type="checkbox"/>	109. Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
(COPD)	<input type="checkbox"/>	<input type="checkbox"/>	Replacement	<input type="checkbox"/>	<input type="checkbox"/>	110. TemporoMandibular Joint		
34. Colitis	<input type="checkbox"/>	<input type="checkbox"/>	72. Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	(TMJ)	<input type="checkbox"/>	<input type="checkbox"/>
35. Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	73. Knee Disorder/injury	<input type="checkbox"/>	<input type="checkbox"/>	111. Tonsils	<input type="checkbox"/>	<input type="checkbox"/>
36. Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	74. Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	112. Transient Ischemic Attack		
37. Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	75. Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	(TIA)	<input type="checkbox"/>	<input type="checkbox"/>
38. Cyst	<input type="checkbox"/>	<input type="checkbox"/>	76. Lou Gehrig's Disease	<input type="checkbox"/>	<input type="checkbox"/>	113. Tremors	<input type="checkbox"/>	<input type="checkbox"/>
39. Depression	<input type="checkbox"/>	<input type="checkbox"/>	77. Lupus	<input type="checkbox"/>	<input type="checkbox"/>	114. Tumor	<input type="checkbox"/>	<input type="checkbox"/>
40. Diabetes or High			78. Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>	115. Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	79. Lymphadenopathy	<input type="checkbox"/>	<input type="checkbox"/>	116. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
41. Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>	80. Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	117. Vertigo or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
42. Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	81. Male Genital Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
43. Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	82. Mental And Nervous					
44. Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
45. Edema	<input type="checkbox"/>	<input type="checkbox"/>	83. Migraines	<input type="checkbox"/>	<input type="checkbox"/>			

**Has anyone applying for coverage (Document details of any "Yes" answers on page 4):**

	Yes	No		Yes	No
118. Been diagnosed or treated for any medical symptom or condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	122. Had Breast Implants or Internal Fixation (plates, screws, pins, shunts, stents, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
119. Had any diagnostic testing, treatment, or surgery recommended or scheduled that has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>	123. Had a routine medical exam or routine PAP Smear?	<input type="checkbox"/>	<input type="checkbox"/>
120. Had any symptoms or conditions for which they intend to seek medical advice or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	124. Been tested positive for, been diagnosed as having, or been treated for:		
121. Taken, or currently take, any medication?	<input type="checkbox"/>	<input type="checkbox"/>	a. Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
			b. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
			c. Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>

**Note:** Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of this policy, if approved, only if such sickness, injury, or condition is fully disclosed on this application and is not excluded from coverage by a rider or policy exclusion.



**G. CONSENT, TERMS AND CONDITIONS**

1. I represent that I have read this Application and understand each of the questions, and that the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any misrepresentation on this Application will void my policy at the discretion of American Community. I further agree that if a policy is issued, it will be issued by American Community in full reliance and in consideration of the information, answers and statements contained herein. I understand that this application will be medically underwritten. I agree to provide American Community with any additional information that may be necessary to complete the underwriting process.
2. I represent that neither I, nor my spouse, is receiving any form of reimbursement or compensation for this coverage from any employer.
3. I understand and agree that no agent or broker has the authority: (i) to bind American Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information American Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of American Community; or (v) waive or alter any of American Community's other rights or requirements.
4. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics, mode of living or type of risk of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records and criminal history.
5. I consent to any physician, hospital, clinic, pharmacy, or other medical or medically related facility and insurance company, health information repository, its agents, business associates, or legal representatives to give to American Community, its legal representatives or its reinsurers any information or records or knowledge of the health, except for psychotherapy notes, of any persons proposed for insurance to carry out treatment, payment and health care operations.
6. An unaltered copy of this authorization is as valid as the original for 24 months from the date signed. I know that I, or my authorized representative, may request and are entitled to receive a copy of the consent.
7. I am signing this Application on my own behalf and on behalf of all listed dependents. I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if my health or any of my answers or statements change prior to delivery of the policy, I must inform American Community in writing. I understand that failure to do so may result in my application being denied or rescission of my policy.
8. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not: a.) provide interim coverage, b.) guarantee coverage, or c.) guarantee issue of a policy.

X _____ <b>Signature Key Applicant</b> (or if minor Child, Parent or Guardian)	_____ Date	X _____ <b>Spouse's Signature</b>	_____ Date
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**WARNING:** Any person who, with intent to defraud or knowing that he or she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Do not cancel any current health insurance coverage until you receive an approval letter and an insurance policy from American Community. You will be notified of the effective date of your policy.**

<p><b>American's Individual Trust ("Trust") Request to Participate</b></p> <p>The applicant hereby requests participation under the Trust in order to buy health insurance under a group master policy issued to the Trust - the Policyholder. The applicant understands and agrees:</p> <p>☞ To be bound by all of the terms of the Trust. (Upon request, American Community will furnish a copy of the Trust agreement to any participant.)</p>	<p>☞ That the insurance is subject in every respect to the group master policy, which alone constitutes the contract under which benefits are paid. (Upon request, American Community will make available for examination to any participant, a copy of the group master policy.)</p> <p>☞ That if the applicant is accepted as a participant under the Trust and issued coverage under the group plan, the applicant will be issued by American Community, a certificate of insurance as evidence of coverage under the group master policy.</p>
X _____ <b>Signature of Key Applicant/Owner</b>	_____ Date Signed

AGENT INFORMATION: Name: _____	Number: _____
Phone # _____	Fax # _____
Signature: X _____	

**Within 60 days of our receipt of the application, we will notify you of the status of the application or give you the reason for further delay.**

## H. AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION:

In order to comply with HIPAA privacy regulations and other privacy laws, I authorize any physician, medical professional, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, health information repository, medical record retrieval service as well as those entities listed below, and their agents, business associates and/or legal representatives to give to American Community Mutual Insurance Company, its legal representatives or its reinsures, any protected health information including medical records, lab work, x-rays, consultation reports, or knowledge of the health of the undersigned for underwriting purposes. This authorization also includes confidential communicable disease related information, confidential HIV-related information, and information about drug and alcohol use. This authorization permits disclosure of medical documents for 5 years prior to the date signed. This authorization includes all health related information except psychotherapy notes.

1. \_\_\_\_\_  
Key Applicant's Name Physician/Facility, Address and Phone Number
2. \_\_\_\_\_  
Spouse's Name Physician/Facility, Address and Phone Number
3. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number
4. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number
5. \_\_\_\_\_  
Child's Name Physician/Facility, Address and Phone Number

This authorization is valid for 24 months from the date below. A photographic copy of this authorization shall be as valid as the original for 24 months from the date below.

I understand and acknowledge that:

1. Execution of this authorization is required for eligibility and enrollment onto this plan. Failure to execute this authorization will result in denial of my application for enrollment.
2. I have the right to revoke this authorization by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
3. American Community must comply with federal privacy laws when using or disclosing health information. There may be times when the health information may be disclosed to another entity and the health information may no longer be protected by federal privacy laws, and may be disclosed by that entity. Examples of the types of entities not subject to federal privacy laws include, but are not limited to, business associates American Community uses to administer its benefits, regulators, and law enforcement officials.
4. If there are specific state laws regarding specific health conditions for which we cannot use this form to obtain health information about you, we will ask you to sign a state specific authorization form.

1. **X** \_\_\_\_\_  
**Signature of key applicant\*** Date Social Security Number Date of Birth
2. **X** \_\_\_\_\_  
**Signature of spouse\*** Date Social Security Number Date of Birth
3. **X** \_\_\_\_\_  
**Signature of dependent** (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth
4. **X** \_\_\_\_\_  
**Signature of dependent** (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth
5. **X** \_\_\_\_\_  
**Signature of dependent** (age 18 and over)\* Date Child's name Child's Social Security Number Date of Birth

\*If under the age of 18, the parent or guardian must sign on the child's behalf and indicate their relationship next to their signature. If you are the individual's representative and are not the parent of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

Applicant **MUST** retain signed yellow copy

## NOTICE OF YOUR PRIVACY RIGHTS

We know that your trust in us is very important. We are committed to protecting your privacy rights. [Please read this document carefully.](#) It discloses your privacy rights.

**Obtaining Information About You** - We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birthday, telephone number, social security number are examples of such information. An investigative consumer report may be prepared where information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted to obtain information as to your character, general reputation and personal characteristics. You may have to share such information with us, our affiliates, agencies or others working with us.

**Our Use of Personal Information** - We will share such information only with companies associated with us. We, or your agent or broker may use your information to offer you products or help you choose a product.

We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

### Your Rights

- ➔ The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
- ➔ The right to request that we correct or amend any personal information that we have about you.
- ➔ To request an interview in connection with the preparation of an investigative consumer report.

To exercise these rights, please send a written request to the attention of the Privacy Coordinator.

**How We Protect Your Personal Information** - We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

### THE REMAINDER OF THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

### STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

- ➔ The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.
- ➔ The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.
- ➔ The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.
- ➔ The right to request that you receive communications of personal medical information in a confidential manner.
- ➔ The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

### PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

**Payment Functions.** We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

**Health Care Operations.** We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

**Group Health Plan.** We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

**Business Associates.** We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

**Uses Permitted By Law.** We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

**Authorized Uses.** All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

**COMPLAINTS ABOUT MISUSE OF INFORMATION** - If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (H.H.S.). Please submit all complaints in writing and to us or H.H.S. as follows:

American Community Mutual Insurance Company  
Attn: Privacy Officer  
39201 Seven Mile Road  
Livonia, MI 48152

U.S. Department of Health and Human Services (H.H.S.)  
Attn: Secretary  
200 Independence Ave S.W.  
Washington, DC 20201

You will not be retaliated against in any way for filing a complaint.

**OBTAINING FURTHER INFORMATION** - Please call American Community at 1-800-991-2642 if you have any questions or comments.

Effective: April 14, 2003